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TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 76  
6010.55-M  
APRIL 16, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.55-M, issued August 2002.

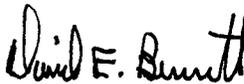
**CHANGE TITLE:** TRICARE REIMBURSEMENT MANUAL (TRM)  
MISCELLANEOUS CHANGES

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change requires that in order to be an  
authorized provider under TRICARE, a Medicare certified Skilled Nursing Facility  
that submits secondary claims for payment to TRICARE must enter into a  
participation agreement with TRICARE. It also clarifies the reimbursement for  
assistant-at-surgery services for physician assistants and clarifies the criteria for  
CMAC waivers for network providers.

**EFFECTIVE DATE:** May 1, 2008.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

  
David E. Bennett  
Acting Chief, Office of Medical Benefits  
and Reimbursement Systems

**ATTACHMENT(S):** 7 PAGE(S)  
**DISTRIBUTION:** 6010.55-M

CHANGE 76  
6010.55-M  
APRIL 16, 2008

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 1**

Section 6, pages 1 and 2

Section 6, pages 1 and 2

**CHAPTER 5**

Section 2, pages 1 through 3

Section 2, pages 1 through 3

**CHAPTER 8**

Section 2, pages 13 and 14

Section 2, pages 13 and 14

## REIMBURSEMENT OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CERTIFIED PSYCHIATRIC NURSE SPECIALISTS

ISSUE DATE: July 9, 1990

AUTHORITY: [32 CFR 199.14\(j\)\(1\)\(x\)](#)

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

### II. ISSUE

How are Physician Assistant (PA), and Nurse Practitioner (NP), and Certified Psychiatric Nurse Specialists (CPNS) services to be reimbursed?

### III. POLICY

A. The allowable charge for the services of the above listed providers may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician. The employing physician of a PA must be an authorized TRICARE provider.

1. When the employing physician of a PA is not participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge determined under the provisions of [Chapter 1, Section 1](#), the allowable charge for the PA service may not exceed 85 percent of the allowable charge for the physician calculated in accordance with these provisions. When the PA and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit components), the allowable charge for the procedure (to include both the services of the physician and PA) may not exceed the allowable charge for the procedure rendered by a physician.

2. When the employing physician is participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge as calculated in [paragraph III.A.1.](#) above, the allowable charge for the PA service may not exceed 85 percent of the reduced allowable charge for the physician unless the reimbursement plan has specifically included use of PAs in the negotiated rates.

B. The allowable charge for PA services performed as an assistant-at-surgery may not exceed **65%** of the allowable charge for a physician serving as an assistant surgeon when

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 1, SECTION 6

REIMBURSEMENT OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND  
CERTIFIED PSYCHIATRIC NURSE SPECIALISTS

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authorized as TRICARE/CHAMPUS benefits in accordance with the provisions of [32 CFR 199.4\(c\)\(3\)\(iii\)](#), and subject to the procedures for calculation contained in [paragraph III.A.1.](#) and [paragraph III.A.2.](#), with the applicability of 65% to PA services.

C. The allowable charge for NP services performed as an assistant-at-surgery may not exceed 85% of the allowable charge for a physician serving as an assistant surgeon.

D. The procedure or service performed by the PA is billed by the supervising or employing physician, billing it as a separately identified line item (e.g., PA Office Visit) and accompanied by the assigned PA provider number.

E. The procedure or service performed by the NP or CPNS is billed by the NP or CPNS. Unlike a PA, a NP or CPNS can bill on their own behalf. Like the PA, the NP or CPNS shall bill using an assigned NP or CPNS provider number.

IV. EFFECTIVE DATES

A. Reimbursement of PA services is effective for services rendered on or after July 1, 1990.

B. Reimbursement of NP services as stated above is effective for services rendered on or after September 1, 2003.

C. Reimbursement of CPNS services shall be 85% of the allowable amounts for physicians effective for services rendered on or after June 1, 2007.

- END -

## LOCALITY-BASED REIMBURSEMENT RATE WAIVER

ISSUE DATE: September 27, 2001

AUTHORITY: [32 CFR 199.14](#)

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### I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

### II. ISSUE

What is the process of the locality-based reimbursement rate waivers?

### III. POLICY

A. On August 28, 2001, the Final Rule was published in the **Federal Register** implementing the FY 2000 and FY 2001 National Defense Authorization Acts (NDAAs) pertaining to waivers to the CHAMPUS Maximum Allowable Charge (CMAC) to ensure access to health care services in the state or locality, assuming that the services are available.

B. Under the locality-based reimbursement rate waiver, two access locations may be considered for provider reimbursement rates above the CMAC. These are:

1. Network Waivers: If it is determined that **the availability of an adequate number and mix of qualified health care providers in a network in a specific locality is not found**, higher rates may be necessary. The amount of reimbursement would be limited to the lesser of (a) an amount equal to the local fee for service charge; or (b) up to 115% of the CMAC. Our first attempt should be to get the provider to join the network at the prevailing CMAC rate.

2. Locality Waivers: If it is determined that access to specific health care services is severely impaired, higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another government payment rate. Higher payments will be paid on a claim by claim basis.

C. Coordination of the request for a locality-based reimbursement rate waiver shall be submitted to the TMA Chief, Medical Benefits and Reimbursement Systems (MB&RS) by the

# TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

## CHAPTER 5, SECTION 2

### LOCALITY-BASED REIMBURSEMENT RATE WAIVER

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Director, TRICARE Regional Office (DTRO). The Director shall work with the Managed Care Support Contractor (MCSC) to ensure that both are in agreement with the waiver request.

D. The procedures that are to be followed when submitting a waiver are as follows:

1. Identify the waiver that is being requested.

a. Network waivers - needed to ensure availability of an adequate number and mix of qualified network providers.

b. Locality waivers - needed to ensure access to services in a locality defined by a current TRICARE locality or a new one established by zip code.

2. Who can apply:

a. DTRO

b. Providers through the DTRO

c. Beneficiaries through the DTRO

d. MCSC through the DTRO

e. Military Treatment Facility (MTF) through the DTRO

3. How to apply:

a. Applicant must submit a written waiver request to the DTRO. The request must justify that access to health care services is severely impaired due to low reimbursement levels (CMAC payment rates).

b. Justification for the waiver must include at the minimum:

- Number of providers in a locality

- Mix of primary/specialty providers needed to meet patient access standards

- Number of providers who are TRICARE participating

- Number of eligible beneficiaries in the locality

- Availability of MTF providers

- Geographic characteristics

- Efforts that have attempted to create an adequate network, including any additional non-health care payments above the CMAC rates made by the MCSC.

- Letters of intent

**TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002**

CHAPTER 5, SECTION 2

LOCALITY-BASED REIMBURSEMENT RATE WAIVER

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- Cost effectiveness

- Other relevant factors that warrant the higher payment to resolve the access to care issue

E. The DTRO shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director or designee through the TMA Contracting Officer (CO) for coordination. Disapprovals by the DTRO will not be forwarded to the TMA Director or designee. The TMA Director or designee is the final approval authority. A decision by the TMA Director or designee to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal.

1. Network waivers: If the TMA Director or designee approves an increase of up to 15% above the CMAC, the contractor will have the authority to offer designated providers up to 15% above CMAC for joining the network.

2. Locality waivers: If the TMA Director or designee approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in that locality would be adjusted by the managed care support contractor in order to improve the access to services.

- END -



## TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

### CHAPTER 8, SECTION 2

#### SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

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Note to [paragraph IV.C.16.](#): Prior to January 1, 2006, the upper 26 RUGs (i.e., the first 26 RUGs listed in [Addendum A, Figure 8-A-1](#)) represent the required SNF level of care during the immediate post-hospital period. With the addition of 9 new RUGs, effective January 1, 2006, the upper 35 RUGs (i.e., the first 35 RUGs listed in [Addendum A, Figure 8-A-2](#)) represent the required SNF level of care during the immediate post-hospital period. A beneficiary who is correctly assigned to one of the upper RUGs under the initial 5 day assessment is automatically classified as meeting the SNF level of care definition and does not require a medical review unless there is a reason to do so (e.g., data analysis suggests an unusual pattern of claims submission). When a beneficiary is correctly assigned to one of the upper RUG-III groups under the initial 5 day assessment, the SNF level of care requirement is met for the period from SNF admission up to and including the assessment reference date for that assessment. This presumption of coverage only applies if the beneficiary is admitted to the SNF immediately following a 3 day qualifying hospital stay, and lasts through the assessment reference date of the 5 day assessment, which must occur no later than the 8th day of the stay due to the 3 day grace period for SNF assessments.

17. If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE. The cover letter to SNFs and the Participation Agreement are provided at [Addendum G](#) which the contractor will send to SNFs. SNFs must provide evidence that they are certified by Medicare (or Medicaid). The contractor will be responsible for verification that the SNF is Medicare-certified (or Medicaid-certified), and has entered into a Participation Agreement with TRICARE. TRICARE will not permit a waiver to allow non-Medicare (or non-Medicaid) certified SNFs to be authorized SNFs under TRICARE. Non-participating SNFs will not be eligible for reimbursement under TRICARE. If a PPS claim is received from a SNF that has not signed a TRICARE Participation Agreement, the contractor will deny the claim and send a Participation Agreement to the SNF for signature. Once the SNF has signed the Participation Agreement, the claim will be processed provided the SNF was Medicare (or Medicaid) certified and met all other TRICARE SNF criteria at the time when the services were furnished to the TRICARE beneficiary.

Note to [paragraph IV.C.17.](#): VA facilities are required to be Medicare approved or they are required to be Joint Commission accredited in order to have deemed status under Medicare or TRICARE. The VA facilities that enter into an MOU with the Department of Defense (DoD) are not required to enter into the Participation agreement provided at [Addendum G](#).

18. At their own discretion, the contractors may conduct any data analysis to identify aberrant PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG.

19. Refer to the TRICARE Systems Manual, [Chapters 2](#) and [4](#) for the SNF PPS related revenue and edit codes.

D. For Admissions on or after August 1, 2003, when TRICARE is Secondary Payer to Medicare:

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#### SKILLED NURSING FACILITY (SNF) PROSPECTIVE PAYMENT SYSTEM (PPS)

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1. TRICARE is the secondary payer to Medicare for SNF care for beneficiaries under age 65 who are eligible for Medicare, with no OHI and for beneficiaries age 65 and over who are eligible for Medicare with less than a 100-day covered Medicare SNF stay with no OHI.

2. The beneficiary has no liability under Medicare for days 1 through 20 therefore, there will not be any unpaid amount for TRICARE to reimburse until day 21. For days 21 to 100, the beneficiary does have a cost-share for which TRICARE will pay the remaining liability as secondary payer.

3. The Medicare-eligible patient will be assessed by the SNF using the MDS.

4. The MDS data will be run through the MDS RUG-III grouper to generate a three-digit RUG-III code. The RUG-III grouper software assigns a RUG-III code for billing and payment purposes. Each Medicare-certified SNF must process the MDS assessment data by using the RUG-III grouper. A two-digit modifier will be added to this to get the 5-digit HIPPS code which the SNF will put on the claim and send that to the Medicare claims processor for payment.

5. For TRICARE For Life (TFL) beneficiaries, the Medicare claims processor will pay the SNF claim as the primary payer and then electronically submit the claim to the TRICARE contractor for secondary payer purposes.

6. For a beneficiary who is both Medicare and TRICARE eligible, TRICARE can pay secondary for a SNF that participates in Medicare **and has entered into** a Participation Agreement with TRICARE. **Upon exhaustion of Medicare benefits**, TRICARE **may** pay primary **to such SNFs**.

7. As secondary payer, TRICARE will use Medicare's determination of coverage rather than performing an additional review. If Medicare denies the services as not medically necessary, TRICARE will also deny the care and the beneficiary will have appeal rights through Medicare.

#### V. MISCELLANEOUS POLICY

A. TMA will follow CMS policy regarding use of the default payment rate whenever the SNF does an off-schedule assessment, a late patient assessment, or in some cases, no patient assessment at all (but can prove patient eligibility). The default payment will always be equal to the lowest RUG-III group rate (currently, this is the payment rate for PA1).

B. Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard, Extra and TFL patients when TRICARE is the primary payer. The review required for the lower 18 RUGs is a requirement for all TRICARE patients when TRICARE is primary (see [paragraph IV.C.16.](#)). There will be no review for Standard, Extra or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for PRIME beneficiaries will remain unaffected.

C. Supplemental care benefits for ADSM will be paid according to the TRICARE SNF PPS. If the ADSM is enrolled to a Military Treatment Facility (MTF), this care must be